

varicose veins by introducing pins through their cavities, and allowing them to remain there for some time. Nine of these cases were cured. He has applied the same treatment to herniary sacs; and the following is a short account of his method, and of the success which he has obtained from it. He passes three or four pins through the herniary coverings close to the inguinal ring, and in order that they may exert a certain degree of compression, as well as of irritation, on the sac, he twists upwards their points and heads, so as to give them a circular direction.

Caution is necessary not to injure the spermatic cord. The inflammation and pain commenced usually on the third or fourth day after the operation, and the pins were removed a few days afterwards. M. Bonnet has treated four cases of inguinal herniæ by acupuncture. In two of these, the herniæ were small, and three weeks sufficed for the cure. The third was more troublesome. It occurred in an old man 67 years of age; and in him the hernia descended to the bottom of the scrotum, and was with difficulty kept up by a truss. Six needles were used. After a month's treatment, this patient could walk about, without any tendency of the viscera to descend. In the fourth case, the hernia was of 30 years' standing; no truss could keep it up; the inguinal aperture was large enough to admit the introduction of five fingers, and the tumour descended a considerable way down the thigh. Five weeks were necessary for the cure. We are assured that all these patients could cough and walk about freely without any escape of the bowels, and that the inguinal ring was so plugged up, that it could no longer be distinctly recognised.—*Ibid.*

**55. Dissection of an Old Dislocation of the Thumb, with Remarks and Experiments.** By J. ADAIR LAWRIE, Professor of Surgery, Glasgow.—I am indebted to Dr. Hunter, Andersonian Professor of Anatomy, for permission to examine and make public the following case:—A female subject was brought into Dr. Hunter's dissecting rooms during the course of last winter, with an unreduced dislocation of the phalanx of the right thumb, on the back part of the metacarpal bone. It was ascertained on inquiry, that the dislocation had existed for three years, and that several unsuccessful attempts had been made to reduce it. The motions had been partially restored and performed without pain. Previous to dissection, the phalanx was seen to be thrown back, with an anterior and posterior prominence. The thumb shortened, the second phalanx not bent on the first, and the articulation between them capable of free flexion and extension. There being no swelling, the nature of the accident was obvious.

**Dissection.—Bones:** the end of the phalanx was thrown on the back and inner part of the metacarpal bone, to the distance of at least an inch. The circumstance of the phalanx being placed on the inner side of the back part of the metacarpal bone is worthy of notice, as I believe that it is almost uniformly so situated in this dislocation. The end of the metacarpal bone projected forwards to a distance corresponding with the displacement backwards, free from muscle or ligament.

**Ligaments.**—The anterior ligament torn from metacarpal bone; the posterior pressed back, but apparently nearly entire. The anterior portion of external lateral torn; the posterior portion stretched, thrown back and across the metacarpal bone; the internal entire. New ligamentous connexions had formed between the displaced bones.

**Muscles.**—Extensors thrown back, and somewhat stretched over the end of the phalanx; of these, however, I cannot speak with certainty; as they were cut before I examined the preparation minutely. Abductor thrown back, and a little stretched. Opponents a little changed. Flexor brevis: on this muscle, and the flexor longus, the alteration of position was most remarkable. Dr. Hunter thought that the brevis was not torn, but that the end of the metacarpal bone had passed between its two portions, one of which was on each side of it, grasping it firmly. Further examination induces me to think that the greater part of the outer head was torn, the end of the metacarpal bone having passed through its fibres, and that the inner head was uninjured, having slipped to the inner side of the metacarpal bone. The tendon of the flexor longus lay on the inner side of the metacarpal bone, along with the inner head of the brevis, pressing on the abductor, and pushing it back, which last muscle, with this exception, was unchanged.

**Nerves.**—The first, or external digital nerve, is thrown to the inside of the

metacarpal bone, and lies imbedded between the phalanx and metacarpal bone, at the points where the former rests on the latter.

*Sesamoid bones* were not connected with the metacarpal bone. It was found that it would injure the preparation if the dissections were carried so far as to ascertain if they were placed between the metacarpal and the phalanx, in which situation I have, however, no doubt that they are.

Although there are several points in the above dissection which were new to me, they had rather the effect of unsettling my previous opinion as to the cause of difficulty in reducing this dislocation, than of satisfying me as to what that cause really is. In the hope of farther elucidating this point, I proceeded to make experiments on the dead body. To detail all these experiments and dissections, (and I have made a great many,) in the order in which they were made, would be tedious and unnecessary. I prefer arranging them into three classes, according to the amount of dislocation produced, and giving one dissection as an example of each class. The experiments consisted in dislocating the articulations, by grasping the phalanges of the thumb and bending them powerfully backwards; and the dissections, in dissecting the parts, and removing one layer of muscular fibres and of ligaments after another, so as to ascertain the true cause of the difficulty of reduction.

**I. Partial dislocation.**—The external characters are—anterior and posterior prominences slight; the posterior projects directly backwards. Phalangeal articulation bent like the dog-head of a gun, and cannot be extended; disfiguration considerable.

*Dissection.*—No muscular fibres torn: abductor and both heads of flexor brevis somewhat stretched and thrown a little back; tendon of flexor longus considerably stretched, but not displaced, retaining its natural position on the forepart of the articulation between the two heads of the brevis.

*Ligaments.*—Anterior partially torn; posterior entire, stretched; external lateral has a few of its anterior filaments torn, its posterior stretched; internal lateral entire, a little thrown back. Articular extremities of bones partially displaced; that of phalanx backwards, and very slightly inwards. Reduction was easily effected; all that was necessary was to extend the articulation between the phalanges; the flexor longus tendon, when brought into a straight line, drew the bones into their place.

**REMARKS.**—I have never seen this dislocation on the living subject. It probably seldom requires surgical treatment, being reduced by the action of the flexor longus or by pressure made by the patient over the articulation. The muscles are too little displaced to oppose much resistance to the reduction.

**II. Complete dislocation.**—External characters: anterior and posterior prominences well marked; the latter a little to inside. Articulation between phalanges bent, but can easily be extended.

*Dissection.*—Abductor and adductor nearly as in the last experiment. Inner half of external head of flexor brevis torn by the end of the metacarpal bone; remaining part lies on the outside of the bone, and thrown back. Internal head lies to the inside of the bone, and somewhat backwards. Tendon of flexor longus thrown from off forepart of articulation to inside of metacarpal bone, and carried considerably backwards, pressing on inner head of brevis and adductor; that part of its sheath connecting it with the articulation, and the end of the metacarpal bone, torn; that connecting it with phalanges entire. Anterior ligament torn, excepting at inner side; posterior entire, stretched; internal lateral entire; anterior part of external lateral slightly torn; posterior part stretched, thrown back, and a little across end of metacarpal bone. Displacement of phalanx backwards does not exceed half an inch. Sesamoid bones remain attached to phalanx. Reduction on dead subject easily effected.

**REMARKS.**—I should not anticipate great difficulty in reducing this dislocation on the living. The causes opposing reduction I conceive to be the following:—

**1st. Muscular contractions.**—The muscles least affected and most easily overcome, are the extensors, abductor, and adductor. The flexor brevis and longus are less easily dealt with; we have seen the metacarpal bone driven through the external head of the brevis, and so situated as to be firmly grasped between its remaining fibres and the internal head, the tendon of the longus on the inside of the articulation dragging the phalanges inwards, and locking them in contact with

the metacarpal bone. These, though rather formidable obstacles, are within the control of bleeding, antimonials, and the pulleys.

2nd. *Ligaments.*—My experiments lead me to conclude that the lateral ligaments have been reckoned of greatly too much importance in this dislocation. If they are the causes of difficulty, the reduction ought to be nearly as difficult on the dead as on the living, which in this degree of dislocation is by no means the case. It is quite a mistake to suppose that the end of the metacarpal bone is grasped by the lateral ligaments, and cannot escape. The internal lateral ligament is little, if at all, implicated in the matter; the external may result in this way. The phalanx being thrown inwards, the external lateral ligament is dragged with it, and thrown a little across the back of the metacarpal bone, and in attempts to reduce the dislocation, catches on the prominence, on the outer and back part of the same bone. If the phalanx is pulled forwards and bent across the palm of the hand, the resistance will probably be considerable, but never such as to require or justify the operation of cutting the ligament. To overcome the difficulty, use the pulleys, press the bones asunder by pushing the metacarpal bone towards the palm, the phalanx towards the dorsum, extend the thumb towards the points of the fingers, not across the palm; next press the metacarpal bone backwards and inwards, the phalanx forwards and outwards; lastly, smartly bend the joint.

3d. The third cause of resistance is the locking of the prominences on the back part of the metacarpal bone, and the fore part of the phalanx. The manipulations recommended ought to overcome this difficulty.

III. This dislocation is also complete, and differs from the last in the following respects:—The displacement is greater, amounting at least to an inch. The end of the metacarpal bone is driven completely through the inner fibres of the external head of the flexor brevis. The anterior ligament is completely torn from the metacarpal bone, and remains attached to the phalanx and sesamoid bones, in such a manner that the torn ligament and sesamoid bones are carried backwards by the phalanx, and placed between it and the metacarpal bone. This state of parts is aggravated and rendered permanent by the contraction of the muscles attached to the sesamoid bones and anterior ligament, which muscles, together with the tendon of the long flexor, only differ from their position as described in last section, in being carried farther back. The result is, that the opening in the ligaments by which the metacarpal bone escaped, is thrown back nearly half an inch, and the remains of that ligament and sesamoid bones form a partition between the displaced ends of the bones, which form a mechanical obstacle to the reduction of the dislocation, in some instances I fear insurmountable. This, I am satisfied, is the true cause of the difficulty experienced in replacing the bones in some cases, and of total failure in others. The position of the digital nerve, in Dr. Hunter's preparation, proves that besides the sesamoid bones and ligament, whatever parts are more firmly connected with the phalanx than with the metacarpal bone, will follow the former backwards, and be wedged between it and the latter. It must further be kept in mind, that, in addition to this mechanical obstacle, we have all the causes of resistance mentioned in the last section.

How are these difficulties to be overcome? I fear, as already hinted, that in many cases the reduction is impossible, without the infliction of an unwarrantable extent of injury on the thumb. I have not yet, in practice, met with an "impossible" case; but whenever the displacement is great,—and I believe the amount of mechanical obstruction will generally correspond with the extent of displacement,—I would recommend the following:—Take a door-key, the open part of the handle of which will rather exceed the length of the first phalanx; put the thumb through it, apply the pulleys, give tartar emetic, and bleed to faintness; extend the pulleys (in the direction recommended in last section) as far as can be safely done; employ the manipulations already described, assisting the flexion with the key, so used that the curve which lies on the dorsum will press on the nail end of the first phalanx, and the opposite curve on the end of the metacarpal bone. This failing, reverse the key, carry the under curve towards the point of the thumb, place the posterior on the displaced end of the phalanx, and throw the parts into forced extension, relaxing at the same moment the pulleys.

I disapprove of cutting; but if a knife is used, employ one which is narrow but strong; pass it into the joint and between the bones, in such a manner as (if possible) to disengage the anterior ligament and sesamoid bones from their unnatu-

ral position. This attempt should be made while the pulleys are in operation. As the external lateral ligament is not the cause of the mechanical obstruction, it is cruel to cut it; moreover, it is useless. I have cut it on the dead subject, and failed to replace the bones. Indeed, I believe that those cases in which the external lateral ligament is most extensively torn, are the most difficult to reduce, because in them the displacement is greatest; and in proportion to the extent of displacement the mechanical obstacle is increased.

Glasgow, August, 1837.

P.S.—Since writing the above, I have had the great pleasure of being introduced to Sir Astley Cooper, during his short visit to Glasgow. I took the opportunity of asking him what he considered the cause of the difficulty of reducing the dislocation. He at once replied, "The sesamoid bones." I asked, if he had verified this by dissection or experiments. To which Sir Astley answered, "In the great toe, but not in the thumb; but I am satisfied that the causes are the same in both." I then mentioned to Sir Astley what I had done on this subject; and I have great satisfaction in being allowed to give his very high authority in confirmation of the opinions given in this paper.

56. *Inflammation of the Testicle cured by Compression.*—Dr. HILDEBRAND states, that since the publication of Fricke's paper on the treatment of orchitis by compression, he had made observations on five cases, consequent on gleet which had been too suddenly arrested by the excessive use of balsam copaiba during the inflammatory stage, by heating drinks, and by sympathetic metastasis of the inflammation. In these five cases it was the left testicle which was affected. In all, Dr. H. applied pressure by means of sticking plaster, after the manner recommended by Fricke (which we have described in a former number of this Journal), without any preparation. In two cases only, when inflammation of the testicle was very excessive, he applied six leeches, and applied warm fomentations to the part for six hours, partly to encourage the bleeding, and partly to lessen the tension of the whole scrotum. In all five cases he had seen the most extraordinary effects in the space of four or five days. The application of the compressive apparatus was not attended with the slightest inconvenience; it succeeded equally well when the patient lay in bed on his back, with his legs well separated, or when he sat on the side of the bed, or edge of a chair. The strips of plaster employed for compression were formed from the emplastrum cerussæ, and were not placed, as Fricke directs, from above downwards, but from the perinæum upwards, each strip half covering the one next to it, and proceeding thus till they came together over the pubis: he then laid a strip of adhesive plaster obliquely across the ends to secure them. From this compression, even when very tight, he has seldom seen any great pain follow. After, from twenty-four to twenty-eight hours, during which time the patients were obliged to lie in bed, with the scrotum well supported, the strips usually became loose from the diminution of the swelling. This loosened plaster was not taken off—the doing so would give great pain—but other slips laid over it, by which the pressure may be still kept up, and increased.—*Dublin Journal*, March, 1837, from *Medicinische Zeitung*.

57. *Treatment of Syphilitic Buboec by Seton.*—Professor LEVICAIRE, of the Marine Hospital, Lyons, states that he has employed the seton most successfully for the cure of syphilitic buboes. His method is the following: "As soon as he perceives that the bubo contains matter, he passes a strong, round, straight, long needle, carrying a thick thread, in the direction of the fold of the groin. The points of entrance and exit are those at which the gland first begins to soften. He permits the seton to remain for only twenty-four or twenty-eight hours in quiet, and sometimes to promote irritation, and prevent the too rapid healing of the openings, moistens it with a weak caustic solution, and for the first days lays on an emollient poultice. When this is no longer necessary, he dresses it with a handful of cotton (unwrought) in order to promote the exit of the matter, the adhesive inflammation, and the development of granulations. This is supported by a bandage round the loins, and exercises a very gentle, steady pressure. Dr. L. thinks every thing disadvantageous which promotes the absorption of the matter. The matter here escapes along the seton; the walls of the abscess come